

SPECIAL NEEDS APPLICATION FORM

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WEBSITE: www.hardeecounty.net/eoc

404 WEST ORANGE STREET

WAUCHULA, FLORIDA 33873

(863) 773-6373 (OFFICE)

PLEASE PRINT CLEARLY

For convenience and comfort, citizens are encouraged to make their own evacuation and shelter plans if possible. As an alternative, the PSN program addresses the needs of people who have medical conditions or need transportation to shelters.

(FOR OFFICE USE ONLY)					
Date Received	Initials	Date Approved	Initials	Date Denied	Initials

PERSONAL INFORMATION

NAME: _____ BIRTH DATE: ____/____/____ AGE: _____

ADDRESS: _____ APT. #: _____
 Street City State Zip Code

P.O. BOX: _____ LIVE ALONE: YES NO
 City State Zip Code (Please Check)

NAME OF COMPLEX: _____ HOW MANY STORY(S): _____

PHONE #: _____ WEIGHT: _____ lbs HEIGHT: _____

LANGUAGE: _____ ENGLISH ONLY _____ SPANISH ONLY _____ BI-LINGUAL

TYPE OF HOME: _____ SINGLE FAMILY _____ MOBILE HOME _____ APARTMENT

CONSTRUCTION: _____ WOOD FRAME _____ BLOCK _____ NOT SURE

LOCAL EMERGENCY CONTACT PERSON: _____ PHONE #: _____

PRIMARY DOCTOR'S NAME: _____ PHONE #: _____

NAME OF HOME HEALTH / HOSPICE / NURSING AGENCY: _____

NAME OF EQUIPMENT & SUPPLY PROVIDER: _____

TRANSPORTATION NEEDS

WILL YOU NEED EVACUATION TRANSPORTATION: YES NO (Please Check)

IF MARKED "YES" ABOVE... WHAT KIND OF TRANSPORTATION DO YOU NEED? _____ AMBULANCE
 _____ STANDARD VEHICLE _____ STRETCHER VEHICLE _____ WHEELCHAIR VEHICLE

PLEASE CHECK THE TYPE OF TRANSPORTATION ASSISTANCE YOU REQUIRE:
 _____ NO TRANSPORTATION IS NEEDED _____ CAN YOU LAY FLAT
 _____ TRANSPORTATION TO SPECIAL NEEDS SHELTER _____ NEED ASSISTANCE ENTERING /
 _____ TRANSPORTATION TO NURSING HOME / HOSPITAL _____ EXITING A VEHICLE

MEDICAL HISTORY (Please Check All That Applies)

_____ SKIN INFECTIONS _____ HEART CONDITION (stable/CHF) _____ OSTOMY
 _____ DEMENTIA (early) _____ HIGH BLOOD PRESSURE _____ (type:) _____
 _____ ARTHRITIS _____ SKIN DISEASE _____ SEIZURES (controlled)
 _____ ASTHMA _____ DIABETES _____ KIDNEY DISEASE (stable)
 _____ BRONCHITIS _____ EDEMA _____ EMPHYSEMA / COPD

_____ MUSCULAR DYSTROPHY (MD) _____ HIP / KNEE REPLACEMENT (less than 6 months)
 _____ STROKE / CVA (limitations) _____ CEREBRAL PALSY (CP)
 _____ OPEN SORES _____ APHASIA
 _____ NEBULIZER _____ OXYGEN USE,
 _____ MULTIPLE SCLEROSIS (MS) _____ L/MIN (liters per minute, number on dial)

_____ COMATOSE _____ DEMENTIA (moderate to late)
_____ PARKINSON'S DISEASE (early) _____ PARKINSON'S DISEASE (advanced)
_____ MEDICAL EQUIPMENT (IV, tube, feeder, indwelling catheter)
_____ SPECIAL DIET (**bring any doctor-prescribed food items with you when you evacuate**)

_____ PSYCHOSIS (uncontrolled) _____ DIALYSIS
_____ UNSTABLE HEART CONDITION _____ HOSPICE
_____ SEIZURES (uncontrolled) _____ CONTAGIOUS DISEASE
(Name:) _____

_____ BLIND _____ HEARING IMPAIRED
_____ SERVICE ANIMAL _____ VISION IMPAIRED
_____ LEGALLY BLIND _____ GLASSES

OTHER MEDICAL CONDITIONS / COMMENTS: _____

MEDICATION (please remember that medicine will need to be in the original bottle): _____

ELECTRICAL NEEDED: _____ CONTINUOUS _____ INTERMITTENT _____ NONE

FOOD or DRUG ALLERGIES: _____ YES IF YES, PLEASE STATE: _____
_____ NO _____

MOBILITY

_____ I WALK WITHOUT HELP _____ I CAN GO TO THE RESTROOM ALONE
_____ I USE A WHEELCHAIR _____ I USE A WALKER
_____ I OWN A WHEELCHAIR _____ I AM BEDRIDDEN
_____ I USE A CANE _____ I CAN FEED MYSELF
_____ I AM WHEELCHAIR BOUND
_____ I HAVE SOMEONE ASSIST ME WITH ALL MY DAILY ACTIVITIES

ADDITIONAL INFORMATION

PEOPLE TO ACCOMPANY YOU TO THE SHELTER: _____ PHONE: _____

DIRECTION TO HOME: _____

COMMENTS: _____

DO YOU OWN A DNR (Do Not Resuscitate): YES NO IF YES, BRING WITH YOU TO SHELTER.

READ AND SIGN

To the best of my knowledge, I certify that this information contained herein is true and correct. I understand that based on the data I have provided, the Hardee County Emergency Management Department in consultation with the Hardee County Health Department will determine which evacuation assistance, if any, this program may be able to provide.

The law permits Hardee County Government, Emergency Services to use and disclose my protected health information, for treatment, payment and health care operations. Understanding the PSN evacuation program is provided at no charge, I also accept responsibility for all expenses associated with any extenuating medical issues that arise.

NAME (print): _____ SIGNATURE: _____

If person completing this form is **NOT** the applicant, please answer the following:

NAME / PHONE: _____ RELATIONSHIP / AGENCY: _____



THANK YOU FOR ALLOWING US TO HELP YOU BE PREPARED.

